Vermont Health Care Innovation Project
Core Team Meeting Minutes

Pending Core Team Approval

Date of meeting: Monday, April 6, 2015, 1:00-3:00pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston.

Agenda Item	Discussion	Next Steps
1. Welcome and Chair's Report	Lawrence Miller called the meeting to order at 1:02. **a) Approval of Meeting Minutes:** Paul Bengtson moved to approve the March 2015 meeting minutes. Al Gobeille seconded. Paul requested an update on the question raised by at the previous meeting about whether VHCIP dollars can be used to lobby State or federal government; Robin Lunge provided an update. Georgia Maheras has checked and VHCIP dollars cannot be used for lobbying. Robin suggested that Georgia contact all Work Group co-chairs to communicate this policy. A roll-call vote was taken and the motion to approve the minutes passed unanimously. **b) Sub-Grant Program Convening – May 27th:** Georgia Maheras gave a brief overview of the planned sub-grant program convenings. The sub-grantees will be convened once in the late spring (scheduled for May 27 at the Capitol Plaza in Montpelier) and again in the fall so that the sub-grantees can learn from one another, discussions can inform work group activities, and sub-grantees can take concrete lessons back to their own projects. The meetings will be a half day each, organized so that half of the sub-grantees present at the spring meeting and the other half present at the fall meeting. The sub-grantees have been organized into four thematic groups: ACOs (will present in May); Transitions of Care (will present in May); Substance Abuse and Stress Management (will present in the fall); and Statewide Best Practices (will present in the fall). The current tentative agenda includes opening remarks, panels and Q&A, and a debrief session. Each sub-grantee will provide in advance a one-page summary of project activities to date and lessons learned. The meeting invitation list will include all Work Group co-chairs, sub-grantee staff, Core Team, VHCIP staff, and our federal partners.	**Georgia will communicate lobbying restrictions on VHCIP funding to Work Group co-chairs.** **Sarah Kinsler will poll Core Team members to schedule a VHCIP Project Meeting in early June 2015.**

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	c) VHCIP Project Meeting: Georgia noted that this meeting, tentatively scheduled for June 3, will be similar to the Project Retreat that took place in November 2014. Multiple members indicated that this date would not work for them. Sarah Kinsler will poll Core Team members to find a better date. **d) Annual Report:** The Year 1 Annual Report was submitted to CMMI on March 30, and is now available online.	

2. Policy Update
 	
a) Year 2 Gate & Ladder Methodology for the Medicaid Shared Savings Program
 	
b) Global Commitment and Choices for Care Waiver Overview
	a) Year 2 Gate & Ladder Methodology for the Medicaid Shared Savings Program: Alicia Cooper presented on proposed changes to the Medicaid Shared Savings Program (VMSSP) Gate & Ladder Methodology.
	• Alicia described Year 1 benchmarks and targets and proposed Year 2 benchmarks and targets.
	  ○ Most measures use national HEDIS benchmarks; for measures without national HEDIS benchmarks, ACOs have improvement targets based on their historic performance.
	  ○ How actively are ACOs using these measures now? Data from Year 1 is just now becoming available. Having benchmarks and targets set prior to Year 1 allowed ACOs to know what they would be measured against; now deciding on changes for Year 2.
	  ○ Al Gobeille noted that there is significant lag time between reporting and results/analyses.
	• Proposed changes to the VMSSP include converting the scale from a percentage of available points to absolute points earned; increasing the gate from 35% to 55%; and allowing ACOs to earn additional "improvement points" for statistically significant improvement on measures with national HEDIS benchmarks. Alicia noted that there are no proposed changes to the Gate & Ladder methodology for the Commercial Shared Savings Program.
	• Alicia described the process by which the proposed changes were discussed at the Payment Models Work Group and addressed the guiding questions reviewed by the Steering Committee.
	
	The group discussed the following:
	• Do improvement points impact the gate and the ladder, or just the ladder? All points that the ACO can earn, whether for attainment relative to national benchmarks or improvement relative to past performance. However, there are a limited number of improvement points ACOs can earn (a total of 8; only for payment measures with national benchmarks, and only for one each). This would require significant quality improvement for the ACO.
	• Why did one Steering Committee member oppose these changes? Al Gobeille noted that we can infer, but we can't be sure of members' thinking.
	• Al does not believe these changes lower the bar. Alicia noted that the 35% gate in Year 1 was chosen because there was limited data to support benchmarks. We now have additional data that allows us to raise the gate.
	
	Public comment:
	• Julie Wasserman requested that Alicia share in general how well ACOs are doing in comparison to the	

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	new 55% gate. Alicia reported that the 35% gate in Year 1 was set with limited data; we now have a better sense of what attributed populations look like and have been able to run preliminary analyses, which indicate ACOs are performing around the 55% level. DVHA is not concerned that this change would be punitive; the change is consistent with the program plan. DVHA also believes the introduction of improvement points is a good change, consistent with the Medicare Shared Savings Program changes for the 2015 performance year, and provides an incentive to continue to improve. • Do all the ACOs have similar levels of information? All ACOs participating in VMSSP have comparable reports from DVHA. It's the same from Medicare for the MSSP. Blue Cross is having a harder time providing reports from the Commercial SSPs. Also, the ACOs may have different abilities to analyze data. Paul Bengtson moved to approve the recommendations as approved at the April 1 Steering Committee meeting. Steve Voigt seconded. A roll call vote was taken and the motion passed unanimously with the exception of Robin Lunge, who was absent for this vote. **b) Global Commitment and Choices for Care Waiver Overview:** Monica Light, Director of Operations for DAIL, presented on the Global Commitment waiver, now consolidated with the former Choices for Care waiver. • Global Commitment 1115 Waiver – demonstration launched in 2005; now includes Choices for Care as of January 30, 2015. • Global Commitment includes all Medicaid services except Disproportionate Share Hospital (DSH) payments. • Vermont is the only state where a state agency acts as the Managed Care Entity. o How is this different from a Managed Care Organization, and is this language also accurate? Because Medicaid Managed Care works differently in Vermont (the Managed Care Entity is a state agency, rather than private), we use the language Managed Care Entity. o The legislature is the ultimate oversight for the Agency of Human Services; however, the Agency is required to follow federal law, which supersedes state law. The Agency of Human Services is the Single State Agency (Medicaid agency), which contracts with DVHA through an inter-governmental agreement (which contracts with other AHS departments) to provide Medicaid services. There is significant oversight by CMS; the legislature has limited authority related to their authority over general fund programs and expenditures. • The waiver supports flexibility in a variety of areas, especially cost effective alternatives and managed care investments that allow the state to fund services which would otherwise not be allowable. This supports a holistic approach to serving individuals and families and better communication and collaborative planning when individuals or families are eligible for multiple services. • All 1115 waivers are required to be budget neutral; the state has a set spending cap for the waiver. o How is the State trending with respect to this budget cap? We are well under the cap. Al Gobeille noted that the Medicaid cost shift keeps actual spending lower than it otherwise would	

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	be; if Vermont's Medicaid rates were higher, this would put us in a more favorable negotiating position when we renegotiated the waiver. Spending caps exclude CHIP, DSH, and enhanced spending on health information technology. • Negotiations for the Global Commitment/Choices for Care consolidation were challenging. CMS has indicated that the next round of waiver negotiations will be more challenging: Vermont's waiver is unique and extremely flexible and sets a precedent that CMS may not want to allow in other states; other states could use similar flexibility in ways that would be harmful to beneficiaries or politically challenging for the federal government. • How would this impact/coordinate with a potential All-Payer Waiver? AOA/GMCB are working with CMMI to coordinate All-Payer Waiver approval and Global Commitment renewal simultaneously to ensure alignment, though Al Gobeille stated that it's too early to know how either of these might look. ○ Susan Wehry noted that having both of these waivers might allow us to meet some of the goals of the Duals demonstration, which Vermont did not pursue. Al Gobeille noted that this is possible but raises challenging questions, including how Medicare Part D and LTSS spending could be included. Lawrence noted that this will be an active conversation. ○ Julie Wasserman noted that there will be a Medicaid expenditure analysis presented at the next DLTSS Work Group meeting; this analysis shows that 70% of Medicaid spending is on behalf of the DLTSS population. Al noted that these services could be included in an All-Payer Waiver; however, they may not be included at Total Cost of Care calculations at the outset. ○ Paul Bengtson is interested in the Accountable Communities for Health model, which could allow for flexible spending over a geographic area, rather than focusing on attributable populations. Al believes that this will depend on getting incentives right.	
4. Financial Update **a) 2014 Financial Overview** **b) Financial Request**	**a) 2014 Financial Overview:** Georgia Maheras presented a Year 1 financial report. She noted that the numbers are accurate in the meeting materials, but the graphics are incorrect at this time. An updated version will be posted to the website. • Slide 2 presents a budget with broad categories; actuals and unpaid contract invoices represent money spent in Year 1; remaining unobligated balance represents funds we planned to spend in Year 1 but did not spend. These remaining unobligated funds are not tied to a line item. • Our carryforward includes about $9 million for which we received approval but which we did not spend; we have proposed to keep all of this money in the existing contracts for which they were approved (for example, if additional funds exist within our contract with Bailit Health Purchasing, that money will stay in that contract). We will come back with a reallocation of some of those funds if we find that we will not spend all of it in current contracts and need to change contract scope. Any new contracts will also come to the Core Team for approval. ○ The $9 million unobligated balance can be used for other things but must be spent in 2015; however, we were instructed by the federal government to spend part of this on the sub-grant program (~$2 million). Georgia is also requesting to use some of these dollars for Learning	

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	Collaboratives (see item 4b); the remainder will be allocated at a later date. ○ How does the Core Team supervise the expenditure of these funds? All fiduciary responsibility resides with the agency or department that holds the contract. Each contract has a business office lead and a program lead who ensure monitoring and oversight are being done properly and contract terms are followed. What is the role of the Core Team in ongoing monitoring? Core Team recommends contracts be executed, executing agency is responsible for monitoring. Lawrence Miller noted that Core Team should be looking at results of these contracts when deciding whether or not to recommends expenditure of additional funds. ○ We have now submitted our carryover request to CMMI seven times; Georgia believes this seventh request will be successful. Challenges in getting carryover approved have been administrative, not about program direction or activities. ○ How are contracts that span different budget categories represented? Georgia described this with Bailit Health Purchasing contracts as an example; Georgia does have spreadsheets that represent all elements of each contract with funds spent on each line item and will share these with Core Team members upon request. **b) Financial Requests:** Georgia provided an overview of financial requests, and suggested we review all financial requests and move to approve them as a group unless there are objections. ○ *Request for reallocation:* $500,000 of unobligated funds to support Learning Collaboratives. $1,150,000 would be the new total for the Learning Collaborative program as a whole. Timeline for spending is somewhat flexible since total for the Learning Collaborative program spans Years 2 and 3, though the $500,000 carried over will need to be spent in Year 2. ▪ $150,000 to CMCM Work Group for expansion to additional communities. ▪ $350,000 to DLTSS Work Group for core competency training for providers around care for DLTSS populations. As with the initial Learning Collaborative proposal, the DLTSS Work Group would need to propose a way to use this money specifically; this proposal would go to Steering Committee and Core Team to approve). • *Request to decrease contracts:* Funds would go back into the project budget to be reallocated. ○ Arrowhead Health Analytics: Decrease due to contract termination without prejudice. ○ HIS Professionals: Services provided support the three ACTT projects. As projects have progressed, we have realized that not all services for which HIS was originally contracted are needed given state staff skills (specifically project management was duplicative); $100,000 will be reallocated. The Core Team will receive a comprehensive update on ACTT projects in June. ○ Wakely Actuarial: Scope was added to this contract last fall to support All-Payer Waiver activities. We've since contracted with another vendor to work on the All-Payer Waiver; these funds would go into that contract (see below). • *Request to increase contracts:*	

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	○ All-Payer Model Contract: This would support additional actuarial work and lead programmatic services. This is a time and materials contract, so if work does not occur we will not pay contractors. Al noted that having actuarial services in this contract will make it much easier to get the information AOA/GMCB need to perform analyses needed to negotiate this waiver. ○ Prevention Institute: RFP resulted in bids higher than anticipated; Population Health Work Group will use savings from Work Group Support contract to supplement this contract. ○ JBS International: RFP resulted in bids higher than anticipated; increase comes from additional stakeholder engagement necessary for landscape review and convening of a project steering committee to guide and inform project work. This project includes a landscape review of telehealth activities in Vermont, a review of national telehealth activities, and recommendations to the HIE/HIT Work Group. Paul Bengtson noted that we are far behind much of the rest of the country in terms of telehealth. Al Gobeille noted that there is a bill in Congress that would change telehealth definition and payment; current regulations impact SASH and others. Georgia noted that JBS is working closely with the federal government around telehealth strategies, which will allow us to get a more realistic set of recommendations. Lawrence Miller noted that in sum, these requests total ~$816,000 in increases; ~$257,000 in decreases. Overall, this is approximately $559,000; these requests further allocate about 5% of total carryover funds (~11.1 million). • Susan Wehry noted that initially we felt the need to hire external project management for the ACTT Project, but now are reallocating to project staff. Georgia noted that the ACTT Project is really three different projects; adding them together is starting to feel artificial. Sue Aranoff added that the timing is also quite different. There was no additional public comment. Susan Wehry moved to approve the requests as a group. Harry Chen seconded. A roll call vote was taken A roll call vote was taken and the motion passed unanimously.	
5. Public Comment	No further public comment was offered.	
6. Next Steps, Wrap Up and Future Meeting Schedule	**Next Meeting:** Monday, May 4, 2015, 1:00pm-3:00pm, 4th Floor Conf Room, Pavilion Building, 109 State Street, Montpelier.	